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Sioux Falls, SD 57109
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sanfordhealthplan.com

Insurance Policy
Plan C

Sanford Health Plan (Referred to in this contract as "we", "us", "our", or “the Plan”) will provide the coverage stated in this policy subject to the provisions and limitations contained herein. We have issued this policy in consideration of the payment of the first premium and the statements made in your application.

Your Right To Examine And Cancel this Policy Within 30 Days
We want you to fully understand and be satisfied with your policy. If for any reason you are not satisfied with your policy, you may cancel it. Return the policy to us or to one or our authorized agents by midnight of the 30th day after you receive it. As soon as possible after we receive this policy, we will refund any premiums you have paid. The policy will be considered to have never been issued. If we have paid claims for you during this inspection period, we have the right to recover any amounts we paid.

Policy Term and Renewal
This policy is automatically renewed each month with your premium payments unless it is terminated by you or us. Renewal premiums must be paid on or before the renewal date or during the 30 days that follow. We cannot refuse to renew this policy or place any restrictions on it if you pay the premiums on time.

We may change the premium rates for this policy. The change may be due to a change in coverage or a new table of rates. We can only change your premium rate if we change it for all policies of the same class in this state. We will tell you in advance of any change in premium rate due to a new table of rates or a change in Medicare’s benefit structure. Your rate changes automatically in January of each year after the 1st of the month following your birth month in which you enter a new age increment. Since benefits are tied to Medicare’s deductible and coinsurance amounts, premium and benefit changes are expected to occur each January.

Notice to Buyer:
This policy may not cover all of the costs associated with medical care incurred by the Buyer during the period of coverage. You are advised to review carefully all policy limitations.

Read Your Policy Carefully. It is a legal contract between you and us.

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IMPORTANT INFORMATION

Your Medicare supplement health care coverage was developed to help you pay for some of your health care expenses not paid in full by Medicare. This *coverage only pays for those services accepted and approved by Medicare with the exception of benefits for medically necessary emergency care in a foreign country offered in Plans C through J.*

To understand your supplemental benefits, you must first understand your Medicare benefits. Therefore, it is very important that you read your *Medicare Handbook* carefully. If you do not have a Medicare Handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

- **MEDICARE PART A**
  Medicare Part A helps pay for inpatient hospital care, care in a skilled nursing facility, home health care, and hospice services. We offer you supplemental benefits in all of these categories except for hospice services.

- **MEDICARE PART B**
  Medicare Part B helps pay for physician services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these categories as stated in *SECTION III: Schedule of Benefits,* with the addition of benefits for medically necessary emergency care in a foreign country offered in Plans C through J.

Medicare SELECT Provider Restrictions

This is a Medicare SELECT supplement insurance policy. Facility Expenses will be denied if you receive inpatient hospitalization services or outpatient surgery services in a non-Network Facility.

The full benefits of your coverage will be paid anywhere if:

1. Services (other than outpatient surgery) are not provided in a Hospital setting (i.e. services are provided in the Physician's offices, in another office setting, or in a skilled nursing facility); or

2. Policyholders require services while traveling outside the service area, on the 1st through 90th day of each trip; AND

3. The services are provided for symptoms requiring Emergency Care or are immediately required for unforeseen illness, Injury or other condition, and it is not reasonable to obtain such services through the Network Hospitals; or

4. Services are not available at a Network Hospital.

Other than outpatient surgery as noted above, there are no restrictions on benefits for services received in a non-Hospital setting beyond standard limitations of this policy.

DEFINITIONS

Definitions of Terms Included In This Policy
This section provides an alphabetical list of certain terms and their meaning as used in this policy. Defined terms are capitalized wherever they occur in the policy.

Accident means injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily injury or any other cause, and occurs while insurance coverage is in force. This definition does not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Assignment means a provider or supplier agrees to accept Medicare's approved charge as full payment for a service or supply. This does not include any deductible or coinsurance amount you are responsible for paying.

Benefit Period means a period of consecutive days that begins with the first day (not included in the previous spell of illness) on which you are furnished inpatient hospital. skilled nursing, or rehabilitation services by a qualified provider in a month for which you are entitled to Medicare Part A benefits. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge).

Calendar Year means the twelve-month period that begins on January 1st and ends with December 31st. When you first become covered under this policy, the first Calendar Year begins for you on the effective date of your policy and ends on the following December 31st.

Co-payment or Coinsurance means that portion of expenses which must be paid by you.

Complaint means an oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve You and/or your provider's complaints. A process has been established for You (or your designees) and your providers to use when You are dissatisfied with the Policy, its providers, or processes.

Covered Services means medically necessary, Medicare-approved services and supplies that qualify for payment of benefits under this policy.

Custodial Care means Room and Board and other care which is provided for a person due to a mental or physical condition mainly to aid the person in daily living or meeting personal needs.

Deductible (may also be called Out-of-Pocket Deductible or Medicare Deductible) means the amount of covered expenses which you must pay yourself before benefits will be paid.

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Grievance means dissatisfaction expressed in writing by You with Our administration, or claims practices, or the provision of services of a Hospital, outpatient surgery center or other healthcare provider.

Health care expenses means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include: home office and overhead costs, advertising costs commissions and other acquisition costs taxes, capital costs, administrative costs and claims processing costs.

Hospital means a place which provides care and treatment for sick or injured persons as resident bed patients. It must also have:

1. A Registered Graduate Nurse (R.N.) on duty or on call at all times to supervise 24-hour nursing service;
2. The means for diagnosis, treatment and surgery on its premises or in facilities available on a contractually prearranged basis; and
3. A physician is present or on call at all times to supervise all care.

It must be licensed by the laws of the jurisdiction where it is located and run as a Hospital as defined by those laws.

Its main purpose must not be to provide rest, educational or custodial care, care for the aged-or treatment such as that provided by a convalescent home or sanitarium. A place that treats mental or nervous disorders, or provides treatment of a physical disability, will be deemed a Hospital even if it does not have a means for surgery, if it qualifies in all other respects.

Injury means accidental bodily injury sustained by the insured which is the direct cause of loss, independent of disease, bodily infirmity or other causes. This definition does not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Inpatient Lifetime Reserve Days means the additional non-renewable 60 days of hospital coverage provided under Medicare Part A for an admission which exceeds 90 days. **Important Note:** Once you use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965" as then constituted or later amended.

Medicare Part A means insurance to cover Hospital expenses, such as Room and Board and other inpatient Hospital services.

Medicare Part B means insurance to cover medical expenses, such as Physicians' services, outpatient Hospital services and a number of other non-Hospital medical services and supplies.

Medicare Eligible Expenses means expenses which are of the kind covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Select Issuer as referred to in this policy, means Sanford Health Plan.

Medicare Select Policy means a Medicare supplement policy that contains restricted Network provisions.

Network Hospital means a Hospital that has an agreement with Us and has been designated by Us to provide services for this product. Each Hospital is only authorized to provide such services within the scope of their licensure.

Non-Network Hospital means a Hospital that does not have an agreement with Us or has not been designated by Us to provide Hospital services for this product.

Medicare Summary Notice (MSN) is a form summarizing the action Medicare took on your claim and what amount, if any, Medicare paid for the services you received.

Nurse means one of the following licensed professionals:

1. Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.); or
3. Licensed Vocational Nurse (L.V.N.).

Physician means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Examiners as a physician, or similar boards in other states, and those licensed persons required by State insurance laws to be reimbursed for services legally performed and covered under this policy. This definition will apply to this policy only to the extent that it is not more restrictive than the definition of *physician* as defined in the Medicare program. Services rendered otherwise shall not be covered by this Policy. "Physician" does not include you or any immediate family member. This exclusion does not apply to those in areas in which the immediate family member is the only physician in the area and acting within the scope of their normal employment.

Policyholder means you, the person who signed for this policy.

Provider means any licensed or approved health care professional including a physician, psychologist (who has a doctorate degree in psychology with two years clinical experience or who meets the standards of a national register), a chiropractor, optometrist, podiatrist, physical therapist, oral surgeon, certified registered nurse anesthetist, or any other provider approved by Medicare.

Restricted Network Provision means any provision which conditions the payments of benefits, in whole or in part, on the use of Network Hospitals.

Service Area means the geographic area approved by the commissioner within which we are authorized to offer a Medicare Supplement policy.

Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. This definition does not include sickness or diseases for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Skilled Nursing Facility means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients' from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare, or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place, and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled means your inability, as a result of injury or sickness, to perform the substantial and material duties of your own occupation or any occupation for which you are fitted by reason of education, training or experience.

We, us or **our** means Sanford Health Plan.

You or **Your** means the insured under this policy.

SECTION I
SERVICES NOT COVERED

We will not allow benefits for:

- Services not allowed by Medicare as Benefits, except as stated in *Section III, Schedule of Benefits.*
- Services denied by Medicare, except as stated in *Section III, Schedule of Benefits.*
- Services that would duplicate benefits provided by Medicare.
- Expenses incurred prior to this policy's effective date or while your policy is not in force.
- Facility Expenses incurred when you receive inpatient hospitalization services or outpatient surgery services in a non-Network Facility.

If you have any questions after reading your Medicare Handbook and this Policy, please call Member Services at (605) 328-6800 or toll free at 1-800-752-5863.

SECTION II
POLICY PROVISIONS

The documents that make up your contract with us consist of:

- The application you submitted,
- This benefits policy, and
- Any amendments.

A. Persons Eligible for Coverage

To be eligible for coverage under this policy, you must be:

1. Eligible for Medicare;
2. Enrolled in both Medicare Parts A and B; and
3. You must physically reside in one of these counties:
   In South Dakota: Aurora, Beadle, Bon Homme, Brookings, Brule, Buffalo, Charles Mix, Clay, Clark, Codington, Davison, Day, Deuel, Douglas, Grant, Gregory, Hamlin, Hanson, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Lyman McCook, Miner, Minnehaha, Moody, Roberts, Sanborn, Spink, Tripp, Turner, Union, or Yankton.
   In Iowa: Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, and Sioux.

B. Effective Date of Insurance

We must receive your Application for Coverage prior to the requested effective date. The effective date of insurance shall then be the date listed on your Application for Coverage or upon underwriting approval (if applicable), whichever is later.

C. Premiums

The premium rate for your coverage is shown in your *Outline of Coverage*, labeled *"Monthly Premium Information."* Regular premiums may be paid by check annually (once a year), semiannually (twice a year), or quarterly (four times a year). Monthly premiums (twelve times a year) must be paid via automatic account withdrawal only.

1. **Premium Changes.** We can only change your premium rate if we change it for all policies of the same class in this state. We will tell you at least 30 days in advance of any change in premium rate due to a new table of rates or a change in Medicare's benefit structure. Since benefits are tied to Medicare's deductible and coinsurance amounts, premium and benefit changes are expected to occur each January.

   We have the right to change your rates upon an increase in your age. Premium changes due to an increase in age automatically occur the first of the month following your birth month in which you enter a new age increment.

2. **Payment of Premium.** Each premium is due at the end of the period for which the proceeding premium was paid. You must make premium payments in the required amount according to our agreed schedule of payments for the duration of the contract.

3. **Lapse in Coverage.** If any renewal premium is not paid within the time allowed for payment, coverage will lapse on the last day of the period for which the premium is paid. If the premium is not paid by that date, the grace period will begin.

4. **Grace Period.** A grace period of 31 days will be granted for the payment of each renewal premium. During this grace period, the policy shall continue in force.

5. **Reinstatement.** If you fail to pay the renewal premium within the 31-day grace period, your coverage will lapse. You may request reinstatement of this policy by submitting an *Application for Coverage*. We will give you written notice of our decision to accept or deny your application. If reinstated, this policy will cover only claims that occurred after the date of reinstatement.

   Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid. In order to be reinstated, you must pay any premiums due from your previous enrollment in the plan.

D. How Payment Works

When a physician or supplier agrees to accept the charge approved by Medicare as full payment for covered services, he or she is said to accept *assignment.* All physicians who participate in the Medicare program agree to accept assignment. If you are not sure if your physician participates in the Medicare program, ask and he or she will tell you.

If a physician does not accept assignment, he or she may collect more than Medicare's approved amount. If you purchased Plan F we will pay this difference for you when this happens.

If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you or, in the event of your death, to your estate.

E. Filing Claims

You do not need to file a claim for your services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare, even if they do not accept assignment. We will accept notice from Medicare Carriers on claims submitted on your behalf by physicians and suppliers or you may submit the Medicare Summary Notice (MSN). Notice of claims should include your name and policy number.

You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us.

Out-of-State Services
If you receive health services outside of your state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive a Medicare Summary Notice (MSN). If the *Notes* section of the MSN says that the information is being sent to your private insurer, we will automatically receive the MSN. If the MSN does not say your private insurer is receiving the information, you need to send the MSN to us so we can process your Medicare supplement benefits. Be sure your identification number and mailing address are shown accurately on the MSN form. You do not need to complete a claim form, just send the MSN, and keep a copy for your own records. Send your MSN to:

Sanford Health Plan
Medicare Supplement Claims
P.O. Box 91110
Sioux Falls, SD 57109-1110

F. Authorized Policy Changes

No agent, employee or representative of ours has authority to change this policy or waive any of its provisions. No change in this policy shall be valid until approved by an executive office of the company and unless such approval be endorsed hereon or attached hereto. Unless the change in benefits is required by law, your acceptance of an amendment must be in writing if the amendment reduces or eliminates benefits or increases benefits accompanied by an increase in premium during the policy term.

G. Medicare Deductible and Coinsurance Changes

If Medicare changes its deductible and co-insurance amounts, your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give you appropriate notice of such change. This usually happens on January 1st of each year.

H. When Coverage Ends

Your coverage will end immediately if any of the following occurs:

1. You fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payment we made, minus any premium paid.
2. You fail to pay your premium by the end of the 31-day grace period.
   a. If you pay by automatic account withdrawal, your coverage will be terminated upon Plan notification of non-sufficient funds in your account.
   b. If you pay by check quarterly, semiannually or annually, you coverage will be terminated the first of the month following the month for which premium was paid.
3. You terminate this policy by giving written notice of termination to Sanford Health Plan. Your coverage will be terminated on the first of the month following the month in which we receive your written notice.
4. You are no longer eligible according to the criteria set forth under "*Persons Eligible for Coverage"* in the *Policy Provisions* Section.

I. Effects of Termination

If your policy is terminated for misrepresentation or the concealment of material facts we will not pay for any services or supplies provided after the date the policy is terminated; we will retain legal rights, including the right to sue based on concealment or misrepresentation; and we may, at our option, declare the policy void.

If, at any time while your insurance under this policy is in effect, we become aware that you are no longer enrolled in both Medicare Parts A and B, we will notify you and you will need to provide the appropriate information to us to process any claim. Failure to be enrolled in Medicare Parts A and B will result in termination of your policy.

If your policy is terminated for reasons other than concealment or misrepresentation of material facts, we may stop payment for any services or supplies the day your policy is terminated.

An exception to this applies in the case of a continuous loss that commenced while this policy is in force. If you receive covered professional or facility services as an inpatient of a hospital or skilled nursing facility on the date this policy terminates, payment for these covered services will end on the earliest of the following:

- the date you are first discharged from the facility following termination of this policy;
- the date the policy coverage period would have ended if this policy had not been terminated, that is, the end of the calendar year during which you were an inpatient;
- the date your Medicare benefits are exhausted if no **additional benefits would** otherwise have been covered under this policy had it remained in effect; or
- payment of maximum benefits.

J. Suspension of Coverage and Reinstatement

1. During Medicaid Eligibility

At your request, your Policy will be suspended for a period of time not to exceed twenty-four (24) months during which you have applied for and are entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify us within ninety (90) days after the date you have become entitled to such assistance.

Provided you notified us within ninety (90) days after the date you have become entitled to Medicaid, we shall return to you that portion of the premium you paid which is attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If your entitlement to this assistance is terminated during the twenty-four (24) month period, and you notify us within 90 days of this termination, coverage that is substantially the same as that in effect at the point of suspension shall be reinstated at premium classification terms that would have applied to you had your coverage never been suspended. You must pay the premium attributable to the period, effective as of the date of termination of Medicaid entitlement.

Reinstatement of Coverage:

- will not provide for any waiting period for treatment of preexisting conditions;
- will provide coverage substantially equivalent to the coverage in effect before the date of suspension; and
- will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

2. During Enrollment in Group Health Plan

You may request a suspension in coverage if you are under age 65, enrolled in Medicare benefits as the result of disability, and enrolled in a group health plan sponsored by you current or former employer or employee organization. To suspend your policy, you must notify us within 90 days after the date you become enrolled in such group coverage. We shall return to you that portion of the premium paid by you which is attributable to the period of the other coverage, subject to adjustment for paid claims.

If a suspension occurs and you lose entitlement to the group coverage, your Medicare supplement policy will be reinstated automatically as of the date your group coverage is terminated if you notify us that you lost your group coverage. You must notify us within 90 days after the date of such loss.

Reinstatement of Coverage:

- will not provide for any waiting period for treatment of preexisting conditions;
- will provide coverage substantially equivalent to the coverage in effect before the date of suspension; and
- will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

K. <u>Our Right to Recover Payments</u>

If for any reason we make payment under this policy in error, we may recover the amount we paid.

1. Subrogation

Once you receive benefits under this policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person's insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage; or
- Other insurance coverage.

You agree to the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we may reasonably require to enforce our rights under this policy;
- You will do nothing to prejudice our rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission; and
- You must reimburse us to the extent of benefit payments made under this policy if payment is received from the other party or parties.
- You must notify us if you have the potential right to receive payment from someone else.
- You must cooperate with us to ensure our rights to subrogation are protected.

L. <u>Notice of Communication</u>

You may send any written notice or communication to our office at:

Sanford Health Plan
Member Services

P.O. Box 91110
Sioux Falls, SD 57109-1110

Any notice from us is acceptable when sent to your address as it appears on our records

M. Legal Actions

No legal or equitable action may be brought against us because of a claim under this policy, or because of the alleged breach of this policy sooner than sixty (60) days from the filing of a claim and not more than three (3) years after the end of the calendar year in which the health care services or supplies were provided.

N. Time Limit On Certain Defenses

After 2 years from the effective date of this policy no misstatements, except fraudulent misstatements, made by you in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing, after the expiration of such 2 year period.

No claim for illness or injury commencing after two (2) years from the effective date of this policy will be reduced or denied on the grounds that the disease or physical condition not excluded from coverage by name or specific description effective on the date of service had existed prior to the effective date of coverage of this policy.

O. Nonassignment

Benefits for covered services in this policy are for your personal benefit and cannot be transferred or assigned to anyone else. Any attempt to assign this policy or rights to payment will be void.

P. Conformity with State And Federal Laws

If any provision of the policy on its effective date is in conflict with the laws of your State on that date, it is amended to conform to the minimum requirements of such laws.

If at any time during the life of the policy, federal or state law changes which would require a corresponding change in the coverage, we reserve the right, subject to regulatory approval, to change policy language, benefits or premium rates, but only insofar as necessary to comply with the changes in law.

To the extent not superseded by the laws of the United States, this policy will be construed in accordance with and governed by the laws of the State. Any action brought because of a claim under this policy will be litigated in the state or federal courts located in your State of residence and no other.

Q. Time Periods

All periods begin and end at 12:00 A.M. Standard Time at your residence.

R. Disclosure Statement

You hereby expressly acknowledge your notice that this policy is a contract solely between you, the policyholder, and us, Sanford Health Plan. You further acknowledge and agree that you have purchased this policy based upon representations by us or our authorized representatives. No person, entity, or organization other than us is

accountable or liable to you for any obligations created under this policy. This paragraph does not create any obligations on our part in addition to those created under the provisions of this policy.

S. Conversion Privilege and Continuation of Coverage

At your request, or in the event you move outside the Network Hospital Service Area, or in the event that the Medicare SELECT program is discontinued for whatever reason, you will have the opportunity to purchase, without evidence of insurability, a Medicare supplement policy which does not contain restrictions on the use of providers.

T. Quality Assurance

When you purchase a Sanford Health Plan Medicare SELECT policy, you agree to use a Sanford Health Plan Network Hospital or outpatient surgery center whenever possible.

Sanford Health Plan ensures high quality healthcare through our Quality Improvement Program. Our Quality Improvement Program allows us to provide accountability for the quality of health care delivery and service. We have a committed Board of Directors and Medical Management Quality and the Health Plan Quality Improvement Committees who develop and carry out a Quality Assurance Plan that has a systematic approach to assessing, measuring, defining and resolving medical care, and behavioral health and service issues.

U. Member Complaints and Appeal Procedures

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. You, health care providers with knowledge of your medical condition, authorized representatives of yours and/or an attorney may appeal any adverse decision by Sanford Health Plan. The following types of denials will be considered for the appeals process.

Types of Denials:

1. Benefits Denial – a denial that is specifically excluded from your benefits package and is not considered a medical necessity denial.
2. Medical Necessity Denial – a denial of care of services that could be considered a covered benefit depending on the circumstances. Examples:
   a. Experimental Treatments
   b. Cosmetic procedures
   c. Pharmaceutical Prior Authorizations
   d. Access to Out-of-Network Practitioners and Providers
3. Claims Denials – denials based on timely and accurate filing of claims and failure to request authorization of services.

Types of Appeals:

Appeal: A request to change any previous adverse decision made by Sanford Health Plan. An appeal can be for a pre or post service request.

Expedited Appeal: A request to change a previous decision made by Sanford Health Plan for an urgent care request.

External Appeal: An external appeal is a request for an independent, external review of the final determination made by Sanford Health Plan through its internal appeals process.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Your and/or your provider's complaints. A process has been established for You (or your designees) and your providers to use when You are dissatisfied with the Policy, its providers, or processes.

Inquiry: A telephone call regarding eligibility, policy interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address member and provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Audit trails for complaints, appeals and denials are provided by Amisys and an access database which includes documentation of the Complaint and/or appeal by date, service, procedure, and member reason. The denial file includes documentation of telephone notification, including the date; the name of the person spoken to; the member; the service, procedure, or admission certified; and the date of the service, procedure, or admission denial and reason for denial. If the Plan indicates certification by use of a number, the number must be called the "authorization number." **Complaints and Appeals can be made for up to 180 days from denial notification.**

We seek to provide quality administration and services to members of Our Medicare SELECT supplement insurance plan and Network Hospitals. However, from time to time, a member may not be fully satisfied with the administration, claims practices or services We provide; or a member may not be fully satisfied with the services provided by a Network Hospital. The Complaint and Grievance procedure, along with a detailed description of how to file a Complaint Or Grievance, will be described in the policy and outline of coverage. You may submit a Grievance within 180 days from the date the Complaint or Grievance arose.

Complaints While Staying At a Network Facility.
If, while staying at a Network facility, You have a Complaint regarding the facility's services being provided, You may contact Our Member Services Department at (800) 752-5863 to express the Complaint. Our Member Services Representatives will relay the Complaint to the facility's Administrator for prompt resolution.

Complaints Other Than While Staying At A Network Facility. If You have questions or are dissatisfied with the quality of care received from a Network facility, or want to contest the disposition of a claim, You may direct such inquiries to Member Services (800) 752-5863 or the address shown on the back of the policyholder identification card without initiating a formal Grievance.

Complaint and Post-Service Appeal Procedure
If You or any authorized representative acting on your behalf, has a question, Complaint or other problem regarding claims payment for a post service(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its providers other than a Complaint regarding certification, or authorization decision, You or your authorized representative should contact the Plan by calling or sending a written Complaint to the following address:

Sanford Health Plan
PO Box 91110

Sioux Falls, SD 57109-1110
Phone: (800) 752-5863 or
(605) 328-6800

The Plan's goal is to make a decision and notify You in writing of its proposed resolution within sixty (60) days of receipt of Complaint. If the issue is unsatisfactorily resolved You will be informed of your right to appeal the decision. Your notification of the Complaint response will be made in writing or by telephone, which will be logged for reference. Any adverse decision notification will advise You of the opportunity to submit written comments, documents or other information related to the appeal. For complaints related to the quality of care, the Plan will, at a minimum, state that your Complaint was received and investigated.

If You or your authorized representative appeals an adverse Complaint response, a thorough investigation of the substance of the appeal including any aspects of clinical care involved will be conducted by an individual designated by the Plan. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the Complaint/post-service appeal.

The Plan will document the substance of the appeal and any actions taken. Full investigation of the substance of the appeal, including any aspects of clinical care involved will be coordinated by the Complaint Coordinator. For medical necessity post-service appeals only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal.

If the post-service appeal response is adverse, You shall be informed of your additional right to contact your State's Division of Insurance or through a court of law.

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Fax: (605) 773-5369
Phone: (605) 773-3563

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
Phone: (515) 281-6348
Toll free: (877) 955-1212

Prior Authorization (Pre-Service) Appeals

The Appeals procedure for Prior Authorization or Pre-Service must be followed when there has been a medical necessity denial that is adverse to You. This adverse determination does not meet The Plan's requirements for medical necessity, appropriateness of health care setting or level of care, and the requested service is therefore denied or payment is reduced. This type of denial could be in relation to experimental treatments, cosmetic procedures, pharmaceutical coverage or access to Nonparticipating Providers. Two types of initial appeals are available to You and providers to address concerns regarding medical determination and prior authorization or pre-service request decisions: an expedited appeals process and a standard appeals process. An expedited appeals process is used when the condition is an emergency or urgent in nature, as defined by the Certificate of Coverage.

Expedited Appeals Process

An expedited review of prior authorization (pre-service) denial determination not to authorize must be utilized if the member or practitioner acting on behalf of the member believes that an expedited determination is warranted. This can be done by oral or written notification to the Plan. The Plan will accept all necessary information (electronic or by telephone) for review from

the practitioner of care. A designated Physician advisor will conduct the review and will be available to discuss the case with the attending practitioner on request.

Telephonic notification of the Plan's expedited decision must be provided to the Hospital, the attending practitioner, and to You as expeditiously as your medical condition requires, but *no later than seventy-two (72) hours* from the initial request.

Written notification of the Plan's expedited decision must be provided to the Hospital, the attending practitioner and You with the decision of prior authorization or denial *within two (2) business days,* providing the initial notification was not in writing.

If the expedited review process does not resolve a difference of opinion, You or your representative may submit a written Grievance, unless the provider is prohibited from filing a Grievance by federal or state law. Sanford Health Plan will review this appeal as a standard appeal.

If the expedited review is a concurrent review determination, the service must be continued without liability to the member until your or your representative has been notified of the determination.

Standard Appeals Process
A standard appeal may be requested by You or your representative or Provider by writing or telephoning the Health Services Department at 1-800-805-7938 or (605) 328-6807 if the medical determination for a request for service was adverse to You. The appeals process is included in your initial denial letter.

You and the attending Practitioner will be made aware, by phone, of your responsibility for submitting the documentation required for resolution of the appeal if needed. Documentation may include sending copies of part or all of the medical record and/or a written statement from the Practitioner. Only the necessary information that pertains to the case in question will be requested. Documentation of the substance of the pre-service appeal and any actions taken will be recorded. If the decision is adverse, the notification will advise You of the opportunity to submit written comments, documents or other information related to the appeal.

Full investigation of the substance of the appeal, including any aspects of clinical care involved will be completed by at least one Physician advisor (may be from the Medical Management, Quality, or Pharmacy & Therapeutics Committee) representing the same or appropriate specialty who is conversant with the appeal process, whose scope of practice includes the services or treatment being reviewed and who was not involved in the initial determination will review the documentation provided.

Determinations will be made within thirty (30) calendar days of receiving the necessary information to complete a standard appeal.

Written Decision Process
The written decision for the Standard (Pre-Service and Post-Service) and Expedited Review (Pre-Service only) must contain the following information:

- Reason for the standard or expedited review decision in an easily understandable language;

- Names, titles, and qualifying credentials of the clinical peer participating in the review process;
- Notification You can receive, upon request, reasonable access and copies of all documents relevant to your appeal;
- Reference to the benefit provision, guideline, protocol and notification that You on request can have a copy of the actual benefit provisions, guidelines, and protocols;
- Statement of the reviewer's understanding of your Grievance and reviewer's decision;
- Reviewer's principal reasons for the decision in sufficient detail for You to respond further;
- Instructions for requesting written statement of clinical rationale, including clinical review criteria used to make the decision if applicable;
- If applicable, a statement containing a description of the process to obtain a standard review of a decision and the written procedures governing a standard review, including any required timeframe for review; and a
- Description of the next level appeal within the organization and or the right to appeal to an external review organization (for medical necessity denials only) as well as any written procedures as it pertains. Final denial letters will contain information on the circumstances under which appeals are eligible for external review and information on how You can seek further information about these rights.

If the pre-service appeal response is adverse, You shall be informed of the additional right to contact you State's Division of Insurance or through a court of law.

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Fax: (605) 773-5369
Phone: (605) 773-3563

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
Phone: (515) 281-6348
Toll free: (877) 955-1212

You will be provided access to and copies of all documents relevant to your appeal (pre-service, post-service and expedited) and determination by requesting this from the Plan by phone or in writing.

SOUTH DAKOTA Independent, EXTERNAL Review of Final Determinations

External Review Requirements:
In the state of South Dakota, where state laws relating to independent, external appeals do not exist, the Plan will follow the procedure for providing independent, external review of final determinations as outlined by the National Committee on Quality Assurance (NCQA). However, South Dakota law supersedes NCQA.
The Plan will provide:

1. You have the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
   a. You are appealing an adverse determination that is based on medical necessity (benefits denials are not eligible), as defined by NCQA;
   b. You have not appealed to the State of South Dakota;
   c. Sanford Health Plan has completed one level of internal appeal review and its decision is unfavorable to You, or has exceeded the time limit for making a decision, or SVHP has elected to bypass the level of appeal with your permission, without good cause and without reaching a decision;
   d. the total costs related to the entire episode of care or course of treatment prescribed by a provider has exceeded $500; and
   e. the request for independent, external review is filed within one hundred eighty (180) calendar days of the date that the Plan's denial decision was made.

2. Notification to You about the independent, external appeal program and decision are as follows:
   a. general communications to You, at least annually, to announce the availability of the right to independent, external review.
   b. Letters informing You and practitioners of the upholding of a denial covered by this standard including notice of the independent, external appeal rights, directions on how to use the process, contact information for the independent, external review organization, and a statement that You do not bear any costs of the independent, external review organization.
   c. The external review organization will communicate its decision in writing to You and the Plan. The decision will include the medical necessity rationale and the time frame for implementation, list of titles and qualifications of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision and instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
   d. The external review organization must also notify You of how and when You will receive any payment or service in the case of overturned denials.

3. Conduct of the appeal program as follows:
   a. Sanford Health Plan contracts with the independent, external review organization that:
      i. conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal.

ii. completes their review and issues a final decision for non-urgent appeals within *thirty (30)* calendar days of the request. For clinically urgent appeals the review and decision will take *three (3)* calendar days, with the possibility of extending to *five (5)* days for good cause. The organization or the treating Physician may identify a clinically urgent appeal.

iii. has no material professional, familial or financial conflicts of interest with Sanford Health Plan.

b. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the independent, external review organization's proceeding or appeal decision.
c. Sanford Health Plan will provide the independent external review organization with all relevant medical records as allowed by state law, supporting documentation used to render the decision pertaining to the member's case (summary description of applicable issues including the Plan's decision, criteria used and clinical reasons, UM criteria, communication from You to the Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.
d. You are not required to bear costs of the independent, external review organization, including any filing fees. However, the Plan is not responsible for costs associated with a hired attorney or traveling to an independent, external review hearing.
e. You or your legal guardian may designate in writing a representative to act on your behalf. A provider may not file an appeal without explicit, written designation by You.
f. The independent, external review organization's decision is final and binding to the Plan and the Plan implements the independent, external review organization's decision within the time frame specified by the independent, external review organization. The decision is not binding to you, because You have legal rights to further pursue appeals in court if You are dissatisfied with the outcome.

Sanford Health Plan obtains from the independent, external review organization, or maintains and tracks, data on each appeal case, including descriptions of the denied item(s), reasons for denial, independent, external review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its medical necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

IOWA INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS
(Iowa Code 514J, IA Rule 191-76):

A. **Notification of right to independent, external review**
For Iowa residents, an independent, external review of their appeal will be re-evaluated through the Iowa Insurance Division. The mechanism for the appeal of a denial of coverage based on medical necessity will follow the examples listed in NCQA Surveyor Guidelines. The Plan's written notification of the Standard Review Determination to the Member will include the following information:

1. Evidence the Member was covered by the Plan at the time the service or treatment was proposed;
2. Evidence the Member has been denied coverage based on a determination by the Plan that the proposed service or treatment does not meet the definition of medical necessity;
3. Evidence the Member, or the Member's treating health care provider acting on behalf of the Member, has exhausted all internal appeal mechanisms provided under the Plan's evidence of coverage.
4. Notification that the request for an external review must be filed within *sixty (60)* days of receipt of the coverage decision from the Plan.

B. Filing a request for external review
To have a denied medical claim re-evaluated by an independent, external review agent, the Member, or the Member's treating health care provider acting on behalf of the Member, must file the following request:

1. The request for external review to the insurance commissioner must be filed within *sixty (60)* days of receipt of the Plan's coverage decision.
2. A request made to the:
   Iowa Insurance Division
   Request for Xrp
   330 Maple Street
   Des Moines, IA 50319.
   Phone: (515) 281-6348. Toll free: (877) 955-1212
3. A copy of the Plan's coverage decision must accompany the written request for an external review;
4. A $25 filing fee is required unless the Member is requesting that the fee be waived. The check should be made payable to the Insurance Division. If a waiver is requested, the request shall include an explanation of why the Member is requesting that the fee be waived.

C. Certification of Request
The commissioner shall have *two (2)* business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria listed in Section A 1-4 in this Independent, External Review Section are satisfied.

The commissioner shall notify the Member, or the Member's treating health care provider acting on behalf of the Member, and the Plan in writing of the certification. The Plan has *three (3)* business days to contest the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for certification, the commissioner, within *two (2)* business days, shall notify the Member, or the Member's treating health care provider acting on behalf of the Member, in writing of the reasons that the request for external review is not eligible for certification.

If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the Plan, the commissioner shall notify the Plan in writing of the reasons for upholding the certification.

The commissioner shall fax the certification decision to the Plan and the Member, or the Member's treating health care provider acting on behalf of the Member, within the two-day period specified above.

D. The external review process

The external review process shall meet the following criteria:

1. The Plan, within three (3) business days of a receipt of an eligible request for an external review from the commissioner, or within three (3) business days of receipt of the commissioner's denial of the Plan's 's contest of the certification of the request, whichever is later, shall do all of the following:
   a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the Plan, or owned or controlled by a trade association of Plans s of which the Plan is a member.
   b. Notify the Member, and the Member's treating health care provider, of the name, address, and telephone number of the independent review entity and of the Member's and treating health care provider's right to submit additional information.
   c. Notify the selected independent review entity by facsimile that the Plan has chosen them to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.
   d. Provide to the commissioner by facsimile a copy of the notices sent to the Member and to the selected independent review entity.

2. The independent review entity, within three (3) business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the Member of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner.

3. The Member, or the Member's treating health care provider acting on behalf of the Member, may object to the independent review entity selected by the Plan or to the person selected as the reviewer by the independent review entity by notifying the commissioner and Plan within ten (10) days of the mailing of the notice by the independent review entity. The commissioner shall have two (2) business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the Member, the Member's treating health care provider, and the Plan .

4. The Plan, within fifteen (15)days of the mailing of the notice by the independent review entity, or within three (3) business days of a receipt of notice by the commissioner following an objection by the Member, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the Plan by the Member or the Member's treating health care provider in support of the request for coverage of a service or treatment under the Plan's 's appeal procedures.
b. Provide to the independent review entity any other relevant documents used by the Plan in determining whether the proposed service or treatment should have been provided.
c. Provide to the commissioner a confirmation that the information required in paragraphs *"a"* and *"b"* has been provided to the independent review entity, including the date the information was provided.

5. The Member, or the Member's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the Plan's 's evidence of coverage, and other newly discovered relevant information. The Member shall have ten (10) business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care provider after the ten-day period.

6. The independent review entity shall notify the Member and the Member's treating health care provider of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under subsection 4. The Member or the Member's treating health care provider shall provide the requested information to the independent review entity within five (5) days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the Plan of this request.
7. The independent review entity shall immediately, but not later than thirty (30) days from the date the independent review entity received the information required under subsection 4 from the Plan, notify the Plan Member or Member’s treating health care provider, and insurance division of the external appeal decision. The initial notification shall be delivered by telephone or fax transmission, and a hard copy of the notice may be delivered by regular mail. The independent review entity, for good cause, may request an extension of time from the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

D. Expedited review

The Member’s treating health care provider shall directly contact the Plan or organized delivery system for an expedited review if the Member’s treating health care provider states that delay would pose an imminent or serious threat to the Member. The Member’s treating health care provider and the Plan shall select, within 72 hours, an independent review entity to conduct the external review. In the event that the Member’s treating health care provider and the Plan cannot reach an agreement upon the selection of an independent review entity, the Member’s treating health care provider shall notify the commissioner who shall select an independent review entity. The Plan and the Member’s treating health care provider shall provide any additional medical information to the review entity. In the event the Plan does not find that a delay would pose an

imminent or serious threat to the Member, the Member's treating health care provider may ask the commissioner to immediately review the request for certification as an expedited review. A review by the commissioner shall follow the 72-hour expedited review time period.

E. Other External Review Provisions

1. A requirement that all reasonable fees and costs of the independent, external review entity be paid by the carrier or organized delivery system.

2. A provision directing each Plan to file with the Commissioner, an annual report including the number of independent, external reviews requested, the number of external review requests certified by the Commissioner, and the number of coverage decisions upheld by an independent, external review entity.

3. Immunity for an independent, external review entity from liability for damages arising out of a determination, unless the determination is made in bad faith or involves gross negligence.

4. That the standard of review to be used by an independent, external review entity is whether the health care service or treatment denied by the Plan or organized delivery system was medically necessary as evidenced by the Member's Certificate of Coverage, and consistent with clinical standards of medical practice.

5. That the review decision by the independent, external review entity is binding upon the Plan and the organized delivery system and that the findings of fact by the independent, external review entity are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts. The Member or the Member's treating health care Provider may appeal the independent, external review entity's decision in Polk County District Court or the district court in the county in which the Member resides. A petition for judicial review must be filed within *fifteen (15)* business days after issuance of the review decision.

6. The Complaint Coordinator will report quarterly to the Plan's Board of Directors and Quality Improvement Committee with regard to the number and nature of reported appeals and their resolutions. The Quality Improvement Committee shall report annually to the Commissioner of Insurance or Health as appropriate, the description of the medical review determinations appeal procedures, those appeals in which adverse determinations are upheld, and those appeals that are not resolved within thirty (30) days.

SECTION III
SCHEDULE OF BENEFITS

PLAN C
SELECT MEDICARE SUPPLEMENT
SCHEDULE OF BENEFITS

Facility Expenses will be denied if you receive inpatient hospitalization services or outpatient surgery services in a non-Network Facility.

Basic "Core" Benefits

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period;

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem rate, or if different than the DRG day outlier per diem rate, the per diem rate at which Medicare was paying on the last day prior to exhaustion of Medicare hospital inpatient coverage, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the Plan's payment as payment in full and may not bill the insured for any balance;

4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, in accordance with federal regulations.

5. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Additional Benefits

6. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount for each benefit period;

7. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

8. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount for each calendar year regardless of hospital confinement; and

9. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, if the care would have been covered by Medicare if provided in the United States and if the care began during the first 60 consecutive days of each trip outside the United States, subject to a deductible for each calendar year of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, the term "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.